SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED APR 7 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2824 -61-011616 STATE FILE NUMBER

AMENDED

DATE AMENDED 2

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1423 Farrar — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First MARYJANA Middle (STANYNIAK) Last STAJNIAK

4. DATE OF DEATH Month Mar. Day 23 Year 1961

5. SEX Female

6. COLOR OR RACE "hite

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 6/15/1898

9. AGE (last birthday) 62 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Poland

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Andrew Zanunce

13b. MOTHER'S MAIDEN NAME Catherine Lesniak

14. NAME OF HUSBAND OR WIFE John Stajniak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **********

16. SOCIAL SECURITY NO. **********

17. INFORMANT John Stajniak — Address 1423 Farrar

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Failure & Nephritis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 593X.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-22-61, to 3-23-61 and last saw her/him alive on 3-23-61
Death occurred at 10:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frank J. Smith [signature]

22b. ADDRESS 4930 Lindell Blvd. St.Louis,Mo.

22c. DATE SIGNED 3-24-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 3/27/1961

23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery

23d. LOCATION (City, town, or county) St. Louis Co. (State) Mo.

24. FUNERAL DIRECTOR JOHN STYGAR & SON — ADDRESS 5541 RIVERVIEW BLVD.

25. DATE RECD. BY LOCAL REG. MAR 24 1961

26. REGISTRAR'S SIGNATURE Carl Smith M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J. M. Rister

Licensed Embalmer No. 3980

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.